KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Division of Health and Environmental Laboratories
CLIA LABORATORY CERTIFICATE CHANGE FORM

CLIA # _____ **Date:** _____

Laboratory Name: _____

Laboratory Address: _____

The following changes in CLIA certificates should be made within 30 days:

DIRECTOR
Name of New DIRECTOR: _____
Signature of New Director: _____

NAME
New NAME of facility:_____

LOCATION
New LOCATION of facility:_____
Phone # change? New Phone: _____ **FAX:** _____

OWNERSHIP
New Owner: _____
EIN # _____

CERTIFICATE TYPE

CURRENT Certificate: _____ **Waiver** _____ **PPM** _____ **Compliance** _____ **Accreditation**
NEW Certificate: _____ **Waiver** _____ **PPM** _____ **Compliance** _____ **Accreditation**
If requesting an accreditation certificate, please specify the accrediting agency:
_____ **JCAHO** _____ **COLA** _____ **CAP** _____ **AABB** _____ **Other, specify:** _____
Laboratory Closing: _____

Effective Date for Changes: _____
Signature of individual completing form: _____
Title: _____
Phone # where you can be contacted: _____

Please return this form to

CLIA Program Office
 # 740 Forbes Field
Topeka, KS 66620
FAX: (785) 296-1638